M•Plan Benefits & Services

Physician Office Services	**Member Cost**
Primary care physician office visits	$20 copay
Visits to specialist upon referral	$20 copay

Services include: Periodic physician check-ups and exams; prenatal and postnatal maternity visits; well child care and routine pediatric visits; immunizations and injections; allergy tests and treatment; hearing exams; care of immediate medical need; mammogram, PSA and colorectal exams & testing

Physician Hospital Services	
Physician services for surgery, visits and examinations	No charge

Inpatient Hospital Services	
Semi-private room and board	$500 per admission

Services include: Private room if medically necessary, operating, recovery rooms and other special units including intensive care Maternity care, Hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services administration of blood and blood plasma; non-experimental organ transplants when prior authorized

Outpatient Services	
Outpatient surgery	$250 per admission
Outpatient services including laboratory, x-ray, EKG and other diagnostic services	No charge
Wellness Testing for Mammogram, PSA and Colorectal exams & testing	No charge
Emergency room services for life-threatening medical emergencies	$75 per visit *(waived if admitted to hospital)*
Immediate/Urgent Care Center visit	$35 per visit

Mental Health Services	
Inpatient mental health services for short-term evaluation, partial hospitalization or day treatment in lieu of inpatient psychiatric care	$500 per admission
Outpatient visits for short-term psychotherapy, crisis intervention or psychiatric testing	$20 copay
Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs)	$20 copay

Substance Abuse Services	
Inpatient substance abuse services for diagnosis and detoxification	$500 per admission
Outpatient visits for short-term evaluation or crisis intervention	$20 per visit

Other Services	
Biotech products/injectable drugs	20% of covered charges
Durable medical equipment when prior authorized	20% of covered charges
Emergency ambulance when medically necessary or when prior authorized	$50 copay per transport
Vasectomies, tubal ligations & diagnostic services to determine cause of infertility	20% of covered charges
Home health care in lieu of hospitalization and when prior authorized	$20 per day
Morbid Obesity Surgery	20% of covered services; limited to one per lifetime
Prosthetic devices and corrective appliances when prior authorized	20% of covered charges
Short-term physical, occupational and speech therapy	$20 copay per visit
Temporomandibular Joint Dysfunction or Disease (TMJ) when medically necessary and prior authorized	Applicable office visit, inpatient and outpatient copays
Transplants	$2,000 copay up to a maximum benefit of $1,000,000

Prescription Drugs	

Generic-equivalent drugs dispensed when available through participating pharmacies; includes oral contraceptives. To be covered, certain prescription drugs will require prior authorization by the Plan.

Generic prescription drugs on the Plan's Formulary	$10 copay
Formulary Brand Name Drugs and Formulary Diabetic Supplies	$20 copay
Brand Name or Generic Non-Formulary drugs	40% of covered charges ($40 minimum, $100 Maximum)
Diaphragms, cervical caps	20% of covered charges

Group has a maximum out-of-pocket of $2,000 per individual and $4,000 per family.

$1 Million Lifetime Maximum Benefit (excluding transplants) per Covered Person

All services must be provided, prior authorized, or referred by the member's participating primary care physician except in cases of life-threatening emergency.

M•Plan Benefits & Services

Exclusions

- Any service not provided, arranged for, prior authorized or approved by the member's primary care physician other than for life-threatening emergency
- Any service not medically necessary
- Services for which coverage is provided or is required to be provided by law in a public/government facility
- Personal comfort items or convenience items in and out of the hospital (e.g. television, telephone)
- Custodial care, nursing care, nursing home care, rest cures, and domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.
- Physical exams required by a third party (e.g. employment, insurance, licensing)
- Dental services except for accidental traumatic injuries to sound natural teeth if treatment occurs within 24 hours of the accidental injury
- Orthodontic services
- Cosmetic surgery
- Invitro fertilizations, artificial insemination and embryo transport services, GIFT and ZIFT
- Transsexual surgery; reversal of sterilization
- Marriage or sex counseling
- The evaluation or treatment of learning disabilities
- Infertility drugs
- Experimental psychiatric procedures, pharmacological regimen and associated health care services and/or those procedures that are not consistent with accepted standard medical practice or services requiring prior approval by any governmental authority prior to use where such approval has not been granted or services not approved for coverage by Medicare
- Long-term mental health and substance abuse services
- Eyeglasses, contact lenses or examinations to prescribe or fit such items (eye refractions)
- Hearing aids
- Chiropractic services
- Podiatry services, unless medically necessary
- Routine foot care
- Over-the-counter (OTC) drugs and any prescription from the non-sedating antihistamine or low-sedating antihistamine class will not be covered when any form of non-sedating antihistamine becomes available OTC.
- Experimental health care services and drugs
- Skilled nursing facility services
- Prescription drugs for the treatment of sexual dysfunction
- Surgically implanted contraceptives
- Family Planning services and supplies for fertility counseling, testing and treatment
- Medications dispensed in a physician's office
- Services or supplies for the treatment of obesity unless medically necessary for life-threatening condition

Limitations

If circumstances arise beyond the control of the Plan (e.g. major disasters, epidemics); services will be rendered only as practicable within the limitations of available facilities and personnel.

If a member refuses recommended treatment for a medical condition when the primary care or referral physician and the Plan believe no acceptable alternative exists, further coverage related to that condition will be denied.

Members must use the Plan's participating providers. These providers are subject to change from time to time, and the Plan does not guarantee the length of service for any of its participating providers.

Copays

Copays are paid at the time of your office visit or when other services are received.

If you have any questions call or write:

M•PLAN CUSTOMER SOLUTIONS CENTER

(317) 571-5320 **or** 1-800-81-MPlan (800-816-7526)

8802 N. Meridian Street, Suite 100

Indianapolis, Indiana 46260

This brochure describes the essential features of the benefit plan and is not intended to be a full description of benefits. The complete program is described in your employers' Group Service Agreement. Your Certificate of Coverage is a complete description of your benefits.